Report on

Market Conduct Examination

of

Coventry Health Care of the Carolinas, Inc.

Morrisville, North Carolina

by Representatives of the

North Carolina Department of Insurance

as of

March 27, 2015

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Raleigh, North Carolina
March 27, 2015

Honorable Wayne Goodwin
Commissioner of Insurance
Department of Insurance
State of North Carolina
Dobbs Building
430 N. Salisbury Street
Raleigh, North Carolina 27603

Honorable Commissioner:

Pursuant to your instructions and in accordance with the provisions of North Carolina General Statute (NCGS) 58-2-131 through 58-2-134 and 58-67-100, a general examination has been made of the market conduct activities of the Health Maintenance Organization (HMO)

Coventry Health Care of the Carolinas, Inc.
(NAIC #95321)
NAIC Exam Tracking System Exam Number: NC299-M44
Morrisville, North Carolina

hereinafter generally referred to as the Company, at the Company's office located at 2801 Slater Road, Suite 200, Morrisville, NC 27560 and at the North Carolina Department of Insurance (Department) office located at 11 S. Boylan Avenue, Raleigh, North Carolina. A report thereon is respectfully submitted.

SCOPE OF EXAMINATION

The North Carolina Department of Insurance conducted a general examination of the Company. The examination commenced on April 28, 2014, and covered the period of January 1, 2012, through December 31, 2013, with analyses of certain operations of the Company being conducted through March 23, 2015. Review of the Company's general administration activities covered the period of January 1, 2009, through December 31, 2013. All comments made in this report reflect conditions observed during the period of examination.

The examination was performed in accordance with auditing standards established by the Department and procedures established by the National Association of Insurance Commissioners (NAIC). The scope of the examination included a review of the Company's practices and procedures in general administration, provider relations and delivery system, utilization management, quality management, provider credentialing, claims practices, policyholder treatment, underwriting practices, and delegated oversight.

It is the Department's practice to cite companies in violation of a statute or rule when the results of a sample show errors/non-compliance at or above the following levels: 0 percent for grievances and the use of contract forms that were neither filed with nor approved by the Department; 7 percent for claims practices; and 10 percent for all other areas reviewed.

EXECUTIVE SUMMARY

This market conduct examination revealed concerns with Company procedures and practices in the following areas:

General Administration – Failure to provide timely written notice regarding changes in the members of the Board of Directors and Officers.

Utilization Management – Failure to provide timely medical necessity and member appeal review acknowledgements and determinations.

Provider Credentialing – Failure to conduct timely provider and facility credentialing and re-credentialing activities.

Policyholder Treatment – Failure to properly address second-level grievance procedures within policy guidelines; and failure to process member grievances according to statute.

Underwriting Practices – Failure to maintain sufficient documentation, and failure to use a rating factor approved by the Department. The Company's rating system utilized inconsistent rounding, not approved by the Department.

Delegated Oversight – Executing provider contracts prior to the Department's approval; failure to receive (or receive timely) quarterly updated provider lists from intermediary and contract organizations; failure to properly monitor the delegated functions of three entities; failure to submit required Third Party Administrator (TPA) certifications and use prescribed TPA certification templates in the annual filing submission to the Department; and failure to conduct a semiannual review, including at least one on-site audit of a TPA in 2013.

Specific violations are noted in the appropriate section of this report. All North Carolina General Statutes and rules of the North Carolina Administrative Code cited in this report may be viewed on the North Carolina Department of Insurance Web site www.ncdoi.com by clicking "INSURANCE DIVISIONS" then "Legislative Services".

This examination identified various statutory violations, some of which may extend to other jurisdictions. The Company is directed to take immediate corrective action to demonstrate its ability and intention to conduct business in North Carolina according to its insurance laws and regulations. When applicable, corrective action for other jurisdictions should be addressed.

All statutory violations may not have been discovered or noted in this report. Failure to identify statutory violations in North Carolina or in other jurisdictions does not constitute acceptance of such violations. Examination report findings that do not reference specific insurance laws, regulations, or bulletins are presented to improve the Company's practices and provide consumer protection.

COMPANY OVERVIEW

History and Profile

The Company was issued its license from the North Carolina Department of Insurance on October 26, 1995, and is domiciled in Morrisville, North Carolina. In addition to North Carolina, the Company is also licensed in South Carolina. On May 14, 2012, Wellpath Select, Inc. changed its name to Coventry Health Care of the Carolinas, Inc. On May 7, 2013, Coventry Health Care, Inc., the parent company of Coventry Health Care of the Carolinas, Inc., was

acquired by Aetna, Inc. The Company offers fully insured products including HMO, POS and PPO plans, as well as an individual market product called Coventry One.

GENERAL ADMINISTRATION

The Company's general administration documentation and activities were reviewed to determine adherence to Company guidelines and compliance with applicable North Carolina statutes and rules. Review of the Company's general administration activities covered the period of January 1, 2009, through December 31, 2013.

The review revealed that for the election of an actuary on December 15, 2009, only two of the three Board Directors signed the 'Unanimous Written Consent'.

The review also revealed that the Company did not have a formal risk management program. However, the examiners observed that certain aspects of risk management were incorporated into the Company's Quality Management Program Description.

Required Written Notice

The Company did not provide timely written notice (within 15 days after the change) to the Department regarding changes to the members of the Board of Directors and Officers, and therefore did not adhere to the provisions of 11 NCAC 20.0602(1). A review revealed the following:

- John Stelben resigned as Assistant Treasurer to WellPath Select, Inc. effective January 1, 2009. Notice was provided to the Department on January 29, 2009.
- Hassan Rifaat resigned as member of Board of Directors for WellPath Select, Inc. effective October 22, 2009. Notice was provided on November 12, 2009.
- John J. Ruhlmann became a member of the Board of Directors for WellPath Select, Inc. effective October 22, 2009. Notice was provided on November 12, 2009.
- John J. Ruhlmann was elected Treasurer for WellPath Select, Inc. effective November 13, 2009. Notice was provided to the Department on November 30, 2009.
- Melinda L. Tuozzo was elected Assistant Treasurer for WellPath Select, Inc. effective November 13, 2009. Notice was provided to the Department on November 30, 2009.

- Kirsten Barnum resigned as an Actuary for WellPath Select, Inc. effective April 16, 2010. Notice was provided to the Department on February 17, 2011.

PROVIDER RELATIONS AND DELIVERY SYSTEM

The Company's provider relations and delivery system activities were reviewed to determine adherence to Company guidelines and compliance with applicable North Carolina statutes and rules.

The contracting and provider services area develops, expands, and maintains provider networks; educates participating providers; resolves provider issues; and retains provider contracts and other records.

Provider Contract Files

Fifty provider contract files were randomly selected for review from a population of 4,301. The contracts were reviewed to determine adherence to Company guidelines and compliance with North Carolina statutes and regulations. No adverse trends or unfair trade practices were observed in this section of the exam.

Facility Contract Files

Fifty facility contract files were randomly selected for review from a population of 493. The contracts were reviewed to determine adherence to Company guidelines and compliance with North Carolina statutes and regulations. No adverse trends or unfair trade practices were observed in this section of the exam.

Network Availability and Accessibility Standards

The Company's standards for provider and facility availability and accessibility, as well as monitoring results showing performance against these standards, were reviewed. No adverse trends or unfair trade practices were observed in this section of the exam.

UTILIZATION MANAGEMENT

The Company's Utilization Management program and activities were reviewed to determine adherence to Company guidelines and compliance with applicable North Carolina Statutes and rules.

As required by the provisions of NCGS 58-50-61, a formal structure has been established to conduct and oversee utilization management functions. The Regional Medical Director has ultimate responsibility for oversight and implementation of the Utilization Management Program. The department is integrated with other operational areas of the Company in adherence to the provisions of NCGS 58-50-61.

Telephone Access

The utilization management staff is available 24 hours a day through a toll-free telephone line for provider and member inquiries for specific utilization management issues. Member calls initially directed to Member Services that request information about specific utilization issues (beyond a coverage determination), are forwarded to the applicable area for handling in adherence to the provisions of NCGS 58-50-61(e)(3). Standards for telephone accessibility have also been established in adherence to the provisions of NCGS 58-50-61(e)(3). The Company did not meet its average speed of answer standard for the months of February and April of 2012. In addition, the Company did not meet its abandonment rate for the months of January through August of 2012. The Company was successful in achieving its abandonment rate standard and its average speed of answer standards in 2013. The Company standards and actual performance are outlined in the following chart.

Performance Measure	Company Standard	Actual Performance	
		2012	2013
Average speed of answer (seconds)	≤ 30.0	19.3	9.7
Abandonment rate (%)	≤ 2.0	10.3	1.1

Medical Necessity Reviews

The scope of utilization management services provided includes: prospective review for hospital admissions and ambulatory care and services; concurrent review of inpatient health services; and retrospective review for referral management, complex case management, and discharge planning.

The Company handles emergency notification in adherence to the provisions of NCGS 58-3-190, which require that the health plan not condition coverage of emergency care upon the member's notification of the receipt of such services.

Noncertifications are communicated to members in adherence to the provisions of NCGS 58-50-61. The notification includes all reasons for the noncertification, including the clinical rationale, the instructions for initiating a voluntary appeal, and the instructions for requesting a written statement of the clinical review criteria used to make the noncertification.

A. Prospective Records Review

The Company completed a total of 17,031 prospective review requests during the examination period. A random sample of 100 prospective review files was examined. Within two files (2.0 percent error ratio), the determination was not communicated within three business days after receiving all necessary information. Therefore, the Company did not adhere to the provisions of NCGS 58-50-61(f).

B. Concurrent Records Review

The Company completed a total of 14,477 concurrent review requests during the examination period. A random sample of 100 concurrent review files was examined. All files were found to be completed in adherence to the provisions of NCGS 58-50-61(f).

C. Retrospective Records Review

The Company completed a total of 2,967 retrospective review requests during the examination period. A random sample of 50 retrospective review files was examined. Within two files (4.0 percent error ratio), the determination was not communicated within 30 days after

receiving all necessary information. Therefore, the Company did not adhere to the provisions of NCGS 58-50-61(g).

Appeals

Members who are not satisfied with utilization review determinations have the right to appeal the Company's decision. A member is entitled to an expedited review of his/her appeal if a delay in the rendering of health care would be detrimental to his/her health.

Appeal Records Review

The Company received a total of 163 member appeals during the examination period. A random sample of 50 appeal files were reviewed to assess the Company's timeliness and adherence to the provisions of NCGS 58-50-61 and 58-50-62, as well as its own policies and procedures. The following issues were noted, therefore, the Company did not adhere to the provisions of NCGS 58-50-61:

- In one file (2.0 percent error ratio), the acknowledgement letter was not sent within three business days of receipt.
- In four files (8.0 percent error ratio), the second-level appeal review panel meeting notification letter was not sent to the insured at least 15 days prior to the hearing date.
- In one file (2.0 percent error ratio), the review was not completed within 30 days of receipt.
- In one file (2.0 percent error ratio), the determination letter did not contain all the required provisions.

The average service time to process a first-level member appeal was 12 calendar days. A chart of the service time follows:

Service Days	Number of Files	Percentage of Total
1 - 7	7	14.0
8 - 14	40	80.0
15 - 21	2	4.0
31 - 60	1	2.0
Total	**50**	**100.0**

QUALITY MANAGEMENT

The Company's Quality Management program and activities were reviewed to determine adherence to Company guidelines and compliance with applicable North Carolina statutes and rules.

Quality Management Plan

The Company has adopted a written quality management plan in accordance with the provisions of 11 NCAC 20.0503. Established policies and procedures guide the staff in plan implementation. The policies address conflict of interest situations, and confidentiality of member health information in accordance with 11 NCAC 20.0508 and 20.0509. The Company has evaluated its quality management program annually as required by 11 NCAC 20.0511.

Quality of Care Grievances

The total population of seven quality of care grievances received by the Company during the examination period was reviewed to determine adherence to the Company's quality management plan, as well as compliance with applicable North Carolina statutes and rules. No adverse trends or unfair trade practices were observed in this section of the exam.

PROVIDER CREDENTIALING

The Company's provider credentialing activities were reviewed to determine adherence to Company guidelines and compliance with applicable North Carolina statutes and rules.

Department Structure and General Operations

The Company has a program to verify that its network providers are credentialed before the Company lists those providers in its provider directory in adherence to the provisions of 11 NCAC 20.0303 and 20.0401. The credentialing program includes provisions for credentialing and re-credentialing a variety of providers. The Company has adopted a written credentialing plan that contains policies and procedures to support the credentialing program in adherence to the provisions of 11 NCAC 20.0403. The credentialing plan, policies, procedures, checklists,

and other documents used by the credentialing staff include all required provisions outlined in 11 NCAC 20.0400.

Provider Credentialing Files

Fifty provider credentialing files were randomly selected for review from a population of 4,301. The review revealed that in four files (8.0 percent error ratio), the Company had not conducted recredentialing activities every three years, therefore, did not adhere to the provisions of 11 NCAC 20.0407. Within three files (6.0 percent error ratio), the application was processed in excess of the 60 day time frame. Therefore, the Company did not adhere to the provisions of 11 NCAC 20.0405.

Facility Credentialing Files

Fifty facility credentialing files were randomly selected for review from a population of 493. The review revealed that in four files (8.0 percent error ratio), the Company had not conducted re-credentialing activities every three years, therefore, did not adhere to the provisions of 11 NCAC 20.0407. Within one file (2.0 percent error ratio), the application was processed in excess of the 60 day time frame. Therefore, the Company did not adhere to the provisions of 11 NCAC 20.0405.

CLAIMS PRACTICES

The Company's claims practices were reviewed to determine compliance with the appropriate North Carolina statutes and rules and the Company's policy provisions. The review encompassed paid and denied claims.

Paid Claims Sample Review

One hundred paid claim files were randomly selected for review from a population of 2,492,082. The claim files were reviewed to determine compliance with the provisions of NCGS 58-3-225. The review revealed the following:

- Two claims (2.0 percent error ratio), were processed beyond 30 days of receipt. Interest was not applicable to these claims due to member deductible application.

- One claim (1.0 percent error ratio), involved lab work ordered by a participating physician from a non-participating lab. The charges were processed with application of out-of-network benefits. The Department requested provider education regarding participating lab utilization.

The average service time to process a claim payment was nine calendar days. A chart of the service time follows:

Service Days	Number of Files	Percentage of Total
1 - 7	58	58.0
8 - 14	21	21.0
15 - 21	14	14.0
22 - 30	5	5.0
31 - 60	2	2.0
Total	**100**	**100.0**

Denied Claims Sample Review

One hundred denied claim files were randomly selected for review from a population of 670,021. The claim files were reviewed to determine compliance with the provisions of NCGS 58-3-225. The review revealed that the explanation of benefits for five claims (5.0 percent error ratio), contained inadequate denial narratives which did not properly explain the reason(s) for the denial.

The average service time to process a claim denial was 11 calendar days. A chart of the service time follows:

Service Days	Number of Files	Percentage of Total
1 - 7	42	42.0
8 - 14	26	26.0
15 - 21	23	23.0
22 - 30	9	9.0
Total	**100**	**100.0**

Claims Processing Standards

The Company's standards for claims processing accuracy and timeliness, as well as, actual performance during the examination period are outlined in the following chart:

Performance Measure	2012		2013	
	Standard (%)	Actual (%)	Standard (%)	Actual (%)
Overall Accuracy	95.0	97.4	95.0	97.5
Timeliness: within 15 days	92.5	93.6	92.5	97.3
Timeliness: within 30 days	99.0	99.8	99.0	99.8

Policy Rescission/Modification Sample Review

Fifty policy rescission/modification files were randomly selected for review from a population of 179 to determine adherence to Company policy and procedure, as well as, to determine adequate documentation and member correspondence. The following items were noted:

- The member correspondence within 21 files (42.0 percent error ratio), erroneously referenced the Managed Care Patient Assistance Program instead of Health Insurance Smart NC.
- One file (2.0 percent error ratio), was missing a letter of rebuttal from the physician.

POLICYHOLDER TREATMENT

The Company's policyholder treatment activities were reviewed to determine adherence to Company guidelines and compliance with applicable North Carolina statutes and rules.

Member Grievances

The Company did not adhere to the provisions of NCGS 58-50-62(f), as the policy titled, "Complaints, Appeals & Grievance Resolution" (rev. 9/22/11) does not reflect that the acknowledgment letter for a second-level grievance will state the availability of assistance from the Managed Care Patient Assistance Program (MCPAP), including the telephone number and address of the program. In addition, the revised policy (rev. 11/27/13) does not reflect that the acknowledgement letter for a second-level grievance will state the availability of assistance from

Health Insurance Smart NC, nor the telephone number and address of the program, which replaced MCPAP and was directed effective by the Department as of July 18, 2012.

The Company did not adhere to the provisions of NCGS 58-50-62(g)(2) as the policy titled, "Member Appeals & Grievance Resolution" (all iterations) does not reflect in the second-level grievance review procedures, that the covered person shall be notified in writing at least 15 days before the review meeting date.

The Company did not adhere to the provisions of 11 NCAC 19.0103 as the consumer complaint log submitted does not contain the Department's file number, the insurer's department subject to the complaint, and the final disposition of the complaint.

Member Grievances Sample Review

Fifty member grievance files were randomly selected for review from a population of 245. The grievance files were reviewed to assess the Company's compliance with the provisions of NCGS 58-50-62, as well as, its own policies and procedures. The review revealed that in six files (12.0 percent error ratio) the acknowledgment letter was either not sent, or was sent beyond three business days of receiving the grievance. Therefore, the Company did not adhere to the provisions of NCGS 58-50-62.

Thirteen first-level grievance files within the sample were escalated to second-level grievance reviews. Review of these files revealed that the Company did not adhere to the provisions of 58-50-62 based on the following findings:

- In 13 files (26.0 percent error ratio), the member was not notified in writing at least 15 days before the review panel meeting date.
- In one file (2.0 percent error ratio), the second-level grievance written decision letter was not issued to the member within seven business days.

In addition, in seven grievance files, the Company did not initially provide the first-level grievance acknowledgement letter to the Department.

The average service time to process a first-level member grievance was 11 calendar days. A chart of the service time follows:

Service Days	Number of Files	Percentage of Total
1 - 7	10	20.0
8 - 14	32	64.0
15 - 21	6	12.0
22 - 30	2	4.0
Total	**50**	**100.0**

UNDERWRITING PRACTICES

The Company's premium rate setting and underwriting activities were reviewed to determine adherence to Company guidelines and compliance with applicable North Carolina statutes and rules.

Employer Group Underwriting

One hundred employer group underwriting files were randomly selected for review from a population of 33,632. All 100 files contained initial and renewal information. Included in this sample were 72 individual cases, 25 small employer groups, and three large employer groups.

Review of the sample files revealed that the Company did not adhere to the provisions of 11 NCAC 19.0104, 19.0106, and/or NCGS 58-67-50 as follows:

- In 35 files (35.0 percent error ratio), the Company did not maintain sufficient documentation to ascertain the selected plan and/or rates sold.
- In 25 files (25.0 percent error ratio), the Company used a normalized medical cost which differed slightly from the rate filed and approved by the Department. The difference was due to the rating system not consistently rounding to three decimal relativities prior to submitting the rates to the Department for approval.
- In four files (4.0 percent error ratio), the Company could not provide the master group contract.
- In one file (1.0 percent error ratio), the Company incorrectly calculated the rate for one of the dependents in the case. Upon the Department's instruction, the Company recalculated/corrected the rate and issued a refund to the insured in the amount of $12.00. The Company submitted supporting documentation to the Department.

DELEGATED OVERSIGHT

The Company's delegated oversight activities and obligations were reviewed to determine adherence to Company guidelines and compliance with applicable North Carolina statutes and rules.

Intermediary Contracts and Management Agreements

Review of the Company's executed contracts with delegated entities and intermediaries revealed that the Company did not adhere to the provisions of NCGS 58-67-30; 11 NCAC 20.0201, and/or 11 NCAC 20.0204 as the Company executed contracts prior to the Department's approval as follows:

- The intermediary agreement with Crescent PPO, Inc. was executed on October 11, 2004, which was prior to the Department's December 2, 2005 approval.
- The medical services agreement with Managed Health Resources, Inc. (which also delegated credentialing functions), was executed on December 20, 2001, which was prior to the Department's September 3, 2003 approval.
- The intermediary agreement with Express Scripts (formerly Medco Health Solutions, Inc.) was executed on February 14, 2012, which was prior to the Department's February 4, 2013 approval.
- The agreement with Rex Healthcare, Inc. was executed on August 15, 2002, which was prior to the Department's April 27, 2006 approval.
- The agreement with UNC Hospitals was executed on August 15, 2002, and the agreement with WakeMed Faculty Physicians was executed on December 2, 2002. Both of these agreements were executed prior to the Department's April 27, 2006 approval.

Review of Actual Monitoring and Oversight

A review was made of the Company's oversight and monitoring of all intermediary and other contracted entities performing delegated functions. The Company did not adhere to the provisions of 11 NCAC 20.0410(2), as it did not receive quarterly updated provider lists (or did not receive the lists timely) from the following intermediary or contract organizations to which it delegated credentialing activities:

- Avesis Third Party Administrators, Inc. (terminated on September 30, 2012) – the second quarter provider update was received on July 24, 2012, a late submission based on the previous quarter's receipt date of April 12, 2012.

- Coastal Carolina Health Network, Inc. – The entity submitted updates as a provider that was added or terminated, therefore, did not consistently submit quarterly updates as required by 11 NCAC 20.04010(2). That was also a violation of the Company's own policy and procedure titled, "Delegated Credentialing and Recredentialing" (Procedure C-4), which required the delegated entity to submit a monthly (and no less than quarterly), report of all newly credentialed/recredentialed providers." The Company received email communication with provider additions/deletions from the entity on: March 20, 2012; August 1, 2012; November 14, 2012; November 21, 2012; February 29, 2013; May 21, 2013; October 4, 2013; and December 6, 2013. Only the November 21, 2012, submission served as an adequate provider update listing.

- Lake Norman CareMed, Inc. – There were no fourth quarter 2012 and first quarter 2013 provider updates; the second quarter 2013 update was received on September 30, 2013, which was a late submission.

- Magellan Behavioral Health, Inc. – The third quarter 2012 provider update was received on October 1, 2012, which was a late submission based on the previous quarter's receipt date of June 8, 2012; the first quarter 2013 provider update was received on April 16, 2013, which was a late submission based on the previous quarter's receipt date of December 17, 2012; the second quarter 2013 provider update was received on October 1, 2013, which was a late submission based on the previous quarter's receipt date of April 16, 2013. Please note that the second and third quarter updates were sent together on October 1, 2013.

The Company did not adhere to the provisions of 11 NCAC 19.0102 and 19.0106 as it could not provide the 2013 provider contract sample monitoring results documentation for Medco/Express Scripts (Provider Participation Agreement review results).

The Company delegates provider availability and accessibility to Vision Service Plan (VSP). VSP has set appointment wait time standards, but did not adequately monitor the established standards during the examination period to determine whether routine eye exams were occurring within 30 days of the request, and whether urgent care was rendered within 24 hours of the request. Therefore, the Company did not adhere to the provisions of 11 NCAC 20.0304.

Avesis Third Party Administrators, Inc. did not have provider-to-member ratios established during the examination period to ensure an adequate provider network based on membership. Therefore, the Company did not adhere to the provisions of 11 NCAC 20.0301(1).

Required Reporting

The Company did not adhere to the provisions of 58-56-26(c) and/or 11 NCAC 12.0332 based on the following findings:

- The Company did not use the prescribed certification template for the calendar year 2011 and calendar year 2012 TPA certifications that were submitted to the Department.
- The Company did not conduct semiannual reviews in 2013, including at least one on-site audit of the TPA operations that were delegated to Vision Service Plan.
- The Company failed to submit the required annual TPA certification for Vision Service Plan.

COMMENTS, RECOMMENDATIONS, AND DIRECTIVES

The Company must provide timely written notice to the Department regarding changes in the members of the Board of Directors and Officers, as well as, timely medical necessity and member appeal review acknowledgements and determinations to members. Additionally, the Company must conduct timely provider and facility credentialing and re-credentialing activities. The Company must properly address second-level grievance procedures within policy guidelines and process member grievances according to statute. The Company must maintain sufficient documentation of and properly use rating factors, which have been approved by the Department. The Company must not execute provider contracts, which have not yet been approved by the Department. The Company must receive timely quarterly updated provider lists from intermediary and contract organizations, as well as, properly monitor the delegated functions of these entities. The Company must submit required TPA certifications, use prescribed TPA certification templates and conduct semiannual reviews (one being on-site) of TPA's.

CONCLUSION

A general examination has been conducted on the market conduct affairs of Coventry Health Care of the Carolinas, Inc. for the period of January 1, 2012, through December 31, 2013, with analyses of certain operations of the Company being conducted through March 23, 2015. Review of the Company's general administration activities covered the period of January 1, 2009, through December 31, 2013.

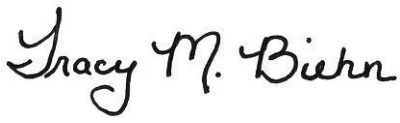
The examination was conducted in accordance with the North Carolina Department of Insurance and the National Association of Insurance Commissioners Market Regulation Handbook procedures, including analyses of Company operations in the areas of general administration, provider relations and delivery system, utilization management, quality management, provider credentialing, claims practices, policyholder treatment, underwriting practices, and delegated oversight.

In addition to the undersigned, Jill H. Dale, PAHM, HIA, MHP, Tanyelle Byrd, MBA, MHA, North Carolina Market Regulation Examiners, and Lalita Wells, JD, CPM, AIAA, ACS, Assistant Chief Examiner participated in this examination and the preparation of this report.

Respectfully submitted,

Scott D. Grindstaff, HIA, MHP
Examiner-In-Charge
Market Regulation Division
State of North Carolina

I have reviewed this examination report and it meets the provisions for such reports prescribed by this Division and the North Carolina Department of Insurance.



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